F. Treatment of Reimbursement for Recipients in the Hospital on the Effective Date of the Hospital Contract

Except where payments are made on a per diem basis, reimbursement to participating hospitals for services provided to Medicaid recipients who are at acute inpatient status prior to October 1, 1996 and who remain at acute inpatient status on October 1, 1996 shall continue to be at the hospital's rates established prior to the RY97/RY98 RFA.

G. Future Rate Years

Adjustments may be made each rate year to update rates and shall be made in accordance with the hospital contract in effect on that date.

H. Errors in Calculation of Pass-through Amounts, Direct Medical Education Cost or Capital Costs

If a transcription error occurred or if the incorrect line was transcribed in the calculation of the RY97 or RY98 pass-through costs, direct medical education costs or capital costs, resulting in an amount not consistent with the methodology, a correction can be made at any time during the first year for errors in RY97 or the second year of the contract for errors in RY98, upon agreement by both parties. Such corrections will be made to the final hospital-specific rate retroactive to the effective date of the contract resulting from the RFA but will not affect computation of the statewide average payment amount or of any of the efficiency standards applied to inpatient or capital costs. Hospitals must submit copies of the relevant report as referenced in Data Sources (Section IV.A), highlighting items found to be in error, to Kiki Feldmar, Division of Medical Assistance, Benefit Services, 5th floor, 600 Washington Street, Boston, MA 02111 during the term of the contract to initiate a correction.

I. New Hospitals

The rates of reimbursement for a newly participating hospital shall be determined in accordance with the provisions of the RFA to the extent the Division deems possible. If data sources specified by the RFA are not available, or if other

factors do not permit precise conformity with the provisions of the RFA, the Division shall select such substitute data sources or other methodology(ies) which the Division deems appropriate in determining the hospital's rates. Such rates shall not affect computation of the statewide average payment amount or any of the efficiency standards applied to inpatient or capital costs.

J. Hospital Change of Ownership

For any hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership, or operation of the hospital, the Division, in its sole discretion, shall determine, on a case-by-case basis (1) whether the hospital qualifies for reimbursement under the RFA, and, if so, (2) the appropriate rate of reimbursement. The Division's determination shall be based on the totality of the circumstances. Any such rate may, in the Division's sole discretion, affect computation of the statewide average payment amount and/or any efficiency standard.

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

TN 96-015
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 1: 130 CMR 415.415, 130 CMR 415.416

415.414: continued

(C) If, as the result of a concurrent review, the Division or its agent determines that a recipient's stay is no longer administratively necessary due to the availability of an appropriate placement, the Division will not pay for any part of the hospital stay that follows ten days after the date of notice to the hospital and to the recipient that the stay is no longer administratively necessary.

(D) If, as the result of a review, the Division or its agent determines that there was no medical or administrative necessity for a hospital admission, a hospital stay, or any part of a hospital stay, the Division will not pay for that admission, stay, or part of a stay.

(E) If, as the result of a review, the Division or its agent denies the need for any hospital service delivered to a recipient during a hospital stay, the Division will not pay for that service.

(F) If a hospital stay or service is reviewed by the Division or its agent concurrently with a recipient's acute hospital admission or stay and the admission, service, and stay, or any part of it, are certified at the time of review as medically or administratively necessary and appropriate, the Division will treat that certification as binding for payment purposes.

(G) If, as the result of a review, the Division or its agent determines that any hospital admission, stay, or service provided to a recipient was subject to a service limitation (see 130 CMR 450.106) and was delivered without obtaining authorization from the recipient's primary-care provider, the Division will not pay for that admission, stay, or service.

(H) Certification of out-of-state hospital claims must be made by the organization responsible for that state's Medical Assistance Program utilization review.

415.415: Reimbursable Administrative Days

(A) Administrative days as defined in 130 CMR 415.402 are reimbursable if the following conditions are met:

(1) the recipient requires an admission to a hospital or a continued stay in a hospital for reasons other than the need for services that can only be provided in an acute inpatient hospital as defined in 130 CMR 415.402 (see 130 CMR 415.415(B) for examples); and

(2) a hospital is making regular efforts to discharge the recipient to the appropriate setting. These efforts must be documented according to the procedures described in 130 CMR 450.205. The regulations covering discharge-planning standards described in 130 CMR 415.419 must be followed, but they do not preclude additional, effective discharge-planning activities.

(B) Examples of situations that may require hospital stays at less than a hospital level of care include, but are not limited to, the following.

(1) A recipient is awaiting transfer to a chronic disease hospital, rehabilitation hospital, nursing facility, or any other institutional placement.

(2) A recipient is awaiting arrangement of home services (nursing, home health aide, durable medical equipment, personal care attendant, therapies, or other community-based services).

(3) A recipient is awaiting arrangement of residential, social, psychiatric, or medical services by a public or private agency.

(4) A recipient with lead poisoning is awaiting deleading of his or her residence.

(5) A recipient is awaiting results of a report of abuse or neglect made to any public agency charged with the investigation of such reports.

(6) recipient in the custody of the Department of Social Services is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.

415.415: continued

(7) A recipient cannot be treated or maintained at home because the primary caregiver is absent due to medical or psychiatric crisis, and a substitute caregiver is not available.
(8) A recipient is awaiting a discharge from the hospital and is receiving skilled nursing or other skilled services. Skilled services include, but are not limited to:
(a) maintenance of tube feedings;
(b) ventilator management;
(c) dressings, irrigations, packing, and other wound treatments;
(d) routine administration of medications;
(e) provision of therapies (respiratory, speech, physical, occupational, etc.);
(f) insertion, irrigation, and replacement of catheters; and
(g) intravenous, intramuscular, or subcutaneous injections, or intravenous feedings (for example, total parenteral nutrition.)

415.416: Nonreimbursable Administrative Days

Administrative days are not reimbursable when:

(A) a hospitalized recipient is awaiting an appropriate placement or services that are currently available but the hospital has not transferred or discharged the recipient because of the hospital's administrative or operational delays;

(B) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and the recipient, the recipient's family, or any person legally responsible for the recipient refuses the placement or services; or

(C) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the recipient.

415.417: Notification of Denial, Reconsideration, and Appeals

(A) Notification of Denial. The Division or its agent shall notify the recipient, the hospital, and the recipient's attending physician whenever it determines as part of a concurrent review that the hospital admission or stay, or any part thereof, is not medically or administratively necessary. The Division or its agent shall notify the hospital and the recipient's attending physician whenever it determines as part of a concurrent or retrospective review that the hospital stay is or was no longer medically necessary but is or was administratively necessary. The Division or its agent shall notify the hospital and the recipient whenever it determines as part of a concurrent review that a hospital stay is no longer administratively necessary due to the refusal of an appropriate placement.

(B) Reconsideration. An agent of the Division under 130 CMR 415.000 may provide an opportunity for reconsideration of a determination made by that agent. If a reconsideration is available, notice of the agent's determination will include written notice of: the right to a reconsideration; the time within and manner in which a reconsideration must be requested; and the time within which a decision will be rendered. A hospital, a physician, or a recipient entitled to have a determination reconsidered must request and have a reconsideration determination given before requesting a hearing under 130 CMR 415.417(C).

(C) Appeals to the Division.
(1) A recipient may request a fair hearing before the Division when the Division or its agent determines as the result of a concurrent review that a continued stay is not administratively necessary due to the availability of an appropriate placement as described in 130 CMR 415.415.

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

TN 96-015
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 2: Chapter 147 of the Acts of 1995, Section 1.

JUN 0 6 1996

OFFICIAL

Chapter 147

Boston Public Health Act of 1995

AN ACT RELATIVE TO PUBLIC HEALTH IN THE CITY OF BOSTON.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Spec L
c. 570
§ 1

SECTION 1. (a) It is hereby declared for the benefit of the people of the city of Boston, in order that there be an increase in their welfare and an improvement in their living conditions, it is essential that a new public health care system be established for the city of Boston that can meet the challenges of a rapidly changing health care environment and ensure the continuous delivery of quality health care to the residents of the city; that the new public health care system must be able to coordinate outreach, health education, prevention, outpatient, home care, emergency, inpatient, specialty, aftercare, rehabilitation, and long term care services in order to create a comprehensive and integrated continuum of care with the goal of promoting health and well-being, meeting the medical and public health needs of all served and of educating future physicians and caregivers; that a new public health commission be created in the city of Boston as the successor to the city's department of health and hospitals in order to better administer, enhance and expand the public health services provided by the city; and that the city's new public health care system should consist of a network of health care providers joining the city's traditional public health services and facilities with private hospitals, community health centers and other associated community based organizations and providers.

(b) It is hereby further declared for the benefit of the people of the city of Boston that the city should be empowered to provide for the establishment of a new medical center as the centerpiece of the city's public health network to be composed of Boston City Hospital, Boston Specialty and Rehabilitation Hospital and a private, nonprofit hospital; that the mission of the new medical center, in partnership with the city's public health commission, community health centers and other community based providers, shall be to consistently provide excellent and accessible health care services to all in need

of care, regardless of status or ability to pay; that recognizing the historic mission and commitment of Boston City Hospital to the public health needs of all residents of Boston, the new medical center shall have a continued commitment to the urban population, to vulnerable populations within the city, including those residents of the city who are underserved by existing health care services, and to other communities served; that the new medical center shall play an important role as a referral, tertiary level hospital serving the region in a financially responsible manner and continue to serve the most acutely ill patient populations; and that in the conduct of this mission, the new medical center shall commit itself to six equally important guiding principles: (1) ensuring the availability of a full range of primary through tertiary medical programs, in addition to a commitment to public health, preventive, emergency and long term rehabilitative care programs; (2) serving both urban and suburban communities in a culturally and linguistically competent manner that strives to meet the current and changing health care needs of people of all races, languages, cultures and economic classes; (3) providing a high degree of medical, nursing, management and technical competency and accountability; (4) enhancing its role as a major academic medical center, including support for bio-medical, public health, medical education and basic science research; (5) providing managed care services to the communities served by the new medical center and participating effectively and competitively in managed care plans serving the patient population; and (6) treating its patients, staff and the communities served with respect and dignity.

Spec L c. S70 § 1

This act may be referred to and cited as the Boston Public Health Act of 1995.

SECTION 2. As used in this act the following words shall, unless the context otherwise requires, have the following meanings:-.

Spec L c. S70 § 2

"Board of health and hospitals", the board of health and hospitals of the city established pursuant to chapter six hundred and fifty-six of the acts of nineteen hundred and sixty-five.

"Boston City Hospital", the hospital located in the city provided for by chapter one hundred and thirteen of the acts of eighteen hundred and fifty-eight under the care and control of the department of health and hospitals, and all branches thereof heretofore or hereafter established, and all other

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

TN 96-015
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 3: Transfer Matrices

TRANSFERRING RULES- BETWEEN TWO HOSPITALS
FOR MEDICAID MANAGED CARE RECIPIENTS ONLY

MH\SA NETWORK** HOSPITAL

TO: RECEIVING HOSPITAL / FROM: TRANSFERRING HOSPITAL	MED SURG	PSYCH	SUB\ABUSE
MH\SA NETWORK** HOSPITAL			
MED\SURG	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: MH\SA CONTRACT RATE	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: MH\SA CONTRACT RATE
PSYCHIATRIC	TRANSFERRING HOSP: MH\SA CONTRACT RATE RECEIVING HOSP: SPAD	TRANSFERRING HOSP: MH\SA CONTRACT RATE RECEIVING HOSP: MH\SA CONTRACT RATE	TRANSFERRING HOSP: MH\SA CONTRACT RATE RECEIVING HOSP: MH\SA CONTRACT RATE
SUBSTANCE ABUSE	TRANSFERRING HOSP: MH\SA CONTRACT RATE RECEIVING HOSP: SPAD	TRANSFERRING HOSP: MH\SA CONTRACT RATE RECEIVING HOSP: MH\SA CONTRACT RATE	TRANSFERRING HOSP: MH\SA CONTRACT RATE RECEIVING HOSP: MH\SA CONTRACT RATE
NON-MH\SA NETWORK HOSPITAL			
MED\SURG	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: MH\SA CONTRACT RATE	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: MH\SA CONTRACT RATE
PSYCHIATRIC	TRANSFERRING HOSP:* NOT REIMBURSABLE RECEIVING HOSP: SPAD	TRANSFERRING HOSP:* NOT REIMBURSABLE RECEIVING HOSP: MH\SA CONTRACT RATE	TRANSFERRING HOSP:* NOT REIMBURSABLE RECEIVING HOSP: MH\SA CONTRACT RATE
SUBSTANCE ABUSE	TRANSFERRING HOSP:* NOT REIMBURSABLE RECEIVING HOSP: SPAD	TRANSFERRING HOSP:* NOT REIMBURSABLE RECEIVING HOSP: MH\SA CONTRACT RATE	TRANSFERRING HOSP:* NOT REIMBURSABLE RECEIVING HOSP: MH\SA CONTRACT RATE

NON-MH\SA NETWORK HOSPITAL

MED SURG	PSYCH	SUB\ABUSE
TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: NOT REIMBURSABLE	TRANSFERRING HO TRANSFER PER DI RECEIVING HOSP: NOT REIMBURSABL
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TRANSFERRING HOSP: MH\SA CONTRACT RATE RECEIVING HOSP: SPAD	TRANSFERRING HOSP: MH\SA CONTRACT RATE RECEIVING HOSP: NOT REIMBURSABLE	TRANSFERRING HO MH\SA CONTRACT RECEIVING HOSP: NOT REIMBURSABL
TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: NOT REIMBURSABLE	TRANSFERRING HO TRANSFER PER DI RECEIVING HOSP: NOT REIMBURSABL
TRANSFERRING HOSP:* NOT REIMBURSABLE RECEIVING HOSP: SPAD	TRANSFERRING HOSP:* NOT REIMBURSABLE RECEIVING HOSP: NOT REIMBURSABLE	TRANSFERRING HO NOT REIMBURSABLE RECEIVING HOSP: NOT REIMBURSABL
TRANSFERRING HOSP:* NOT REIMBURSABLE RECEIVING HOSP: SPAD	TRANSFERRING HOSP:* NOT REIMBURSABLE RECEIVING HOSP: NOT REIMBURSABLE	TRANSFERRING HO NOT REIMBURSABLE RECEIVING HOSP: NOT REIMBURSABL

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IN CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, AND SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

** Applies to non-MH/SA Network Hospitals with agreements with the Divisions MH/SAP provider for the relevant services.

TRANSFERRING RULES- WITHIN A HOSPITAL

MANAGED CARE RECIPIENT

NON-MANAGED CARE RECIPIENT

TO: RECEIVING UNIT

FROM : TRANSFERRING UNIT	MED SURG	PSYCH	SUB\ABUSE
MH\SA NETWORK** HOSPITAL	MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE
	PSYCHIATRIC	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
	SUBSTANCE ABUSE	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
NON-MH\SA NETWORK HOSPITAL	MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE
	PSYCHIATRIC	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE
	SUBSTANCE ABUSE	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE

MED SURG	PSYCH	SUB\ABUSE
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANS PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY

OFFICIAL JUN 06 2001

IN CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, AND SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

* Applies to non-MH/SA Network Hospitals with agreements with the Divisions MH/SAP provider for the relevant services.

TRANSFERRING RULES- BETWEEN TWO HOSPITALS
FOR NON-MANAGED CARE RECIPIENTS ONLY

MH\SA NETWORK
OR NON-MH\SA
NETWORK HOSPITAL

FROM : TRANSFERRING HOSPITAL / TO : RECEIVING HOSPITAL	MED SURG	PSYCH	SUB\ABUSE
MED\SURG	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: PSYCH PER DIEM	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD
PSYCHIATRIC	TRANSFERRING HOSP: PSYCH PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: PSYCH PER DIEM RECEIVING HOSP: PSYCH PER DIEM	TRANSFERRING HOSP: PSYCH PER DIEM RECEIVING HOSP: SPAD
SUBSTANCE ABUSE	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: PSYCH PER DIEM	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD

IN CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, NO SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

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Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
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EXHIBIT 4: 130 CMR 435.409

435.407: continued

(B) All administrative and processing costs associated with the provision of blood and its derivatives are allowed for in the rate-determination process and are not separately reimbursable.

(C) If a recipient occupies a private room, the hospital will not be paid more for the cost of that room than the inpatient room charge approved by the Massachusetts Division of Health Care Finance and Policy. Furthermore, the hospital shall not bill the recipient for such charges.

(D) Research and the provision of experimental procedures are not reimbursable.

(E) Leave-of-absence days taken by a recipient are not reimbursable. For billing purposes, leave-of-absence days are to be treated in the same way as discharge and admission days. Thus, the day on which the recipient leaves the chronic-disease or rehabilitation hospital to start a leave of absence is not reimbursable, regardless of the hour of discharge, while the day on which the recipient returns is reimbursable.

(F) Rest-home (level IV) services are not reimbursable.

435.408: Screening Program for Chronic-Disease and Rehabilitation Hospitals

(A) Introduction. The screening program applies to all in-state and out-of-state chronic-disease and rehabilitation hospitals, except those participating in a managed-care program for all inpatients (see 130 CMR 435.402). The screening program described in 130 CMR 435.408 is intended to ensure that medical and nursing services are medically necessary. The Division will pay for chronic-disease and rehabilitation hospital services only when the Division or its agent determines, pursuant to a screening, that such services are medically necessary and authorizes such services prior to admission or conversion.

(B) Screening.

(1) To initiate admission or conversion screening, the hospital must telephone the Division or its agent prior to the proposed admission or anticipated conversion and must:

(a) describe the medical condition that necessitates a chronic-disease or rehabilitation hospital admission or continued stay; and

(b) state the anticipated length of stay.

(2) The Division or its agent will apply the level-of-care criteria stated in 130 CMR 435.409 or 435.410, whichever is applicable, to determine the medical necessity of the proposed admission or continued stay, as well as the anticipated length of stay.

(3) If the Division or its agent determines that the proposed admission or continued stay is not medically necessary and denies authorization for such admission or continued stay, the hospital may appeal the denial as stated in 130 CMR 435.408(C).

(4) If the Division or its agent determines that the proposed admission or continued stay is medically necessary, the admission or continued stay will be authorized with a specified, approved length of stay, and the hospital will be issued a preapproved screening number to be used when billing for the hospital stay. Approval may be given by telephone; however, authorization for payment is contingent upon receipt of written authorization from the Division or its agent. The Division will not pay the hospital for any costs incurred after the expiration of the specified, approved length-of-stay period.

435.409: Level-of-Care Criteria for Recipients in Chronic Disease and Massachusetts Department of Public Health Hospitals

(A) Introduction. Services in chronic disease and Massachusetts Department of Public Health hospitals are reimbursable only when the recipient meets the level-of-care criteria in 130 CMR 435.409(B)(1) or (2).

(B) Level-of-Care Criteria. In determining medical necessity, the Division or its agent will apply the criteria in 130 CMR 409(B)(1) and (2). In addition, the Medicare Adult Appropriateness Evaluation Protocol (AEP) utilized by the Peer Review Organization (PRO) will be used as a guide. To be medically necessary, an admission to or continued stay in a chronic disease or Massachusetts Department of Public Health hospital must meet one of the following two criteria, in compliance with 130 CMR 450.204.

435.409: continued

(1) The recipient must require services that:
(a) can be provided safely and effectively at a chronic disease hospital level. Such services must be ordered by a physician and documented in the recipient's record; and
(b) include at least daily physician intervention or the 24-hour availability of medical services and equipment available only in a hospital setting.
(2) The recipient's medical condition and treatment needs are such that no effective, less costly alternative placement is available to the recipient.

435.410: Level-of-Care Criteria for Rehabilitation Hospitals

(A) Introduction. A recipient is considered appropriate for rehabilitation hospital placement only when a medical need exists for an intensive rehabilitation program that includes a multi-disciplinary approach to improve the recipient's ability to function to his or her maximum potential. Factors must be present in the recipient's condition that indicate the potential for functional movement or freedom from pain. A recipient who requires therapy solely to maintain function is not considered an appropriate rehabilitation hospital patient.

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

TN 96-015
STATE PLAN AMENDMENT
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EXHIBIT 5: 130 CMR 433.000 et seq.

130 CMR 433.000: PHYSICIAN SERVICES

Section

433.000: continued

433.401: Definitions

The following terms used in 130 CMR 433.000 shall have the meanings given in 130 CMR 433.401 unless the context clearly requires a different meaning.

Adult Office Visit -- a medical visit by a recipient 21 years of age or older to a physician's office or to a hospital outpatient department, emergency room, or courtesy room. Well visits are not reimbursable when performed in the emergency room.

Consultant -- a licensed physician whose practice is limited to a specialty and whose written advice or opinion is requested by another physician or agency in the evaluation or treatment of a recipient's illness or disability.

Consultation -- a visit made at the request of another physician.

Cosmetic Surgery -- a surgical procedure that is peformed for the exclusive purpose of altering appearance and is unrelated to physical disease or defect, or traumatic injury.

Couple Therapy -- therapeutic services provided to a couple for whom the disruption of their marriage, family, or relationship is the primary reason for seeking treatment.

Diagnostic Radiology Service -- a radiology service intended to identify an injury or illness.

Domiciliary -- for use in the recipient's place of residence, including a long-term-care facility.

Emergency -- a sudden or unexpected illness or injury that must be treated promptly to prevent harm to the recipient.

Emergency Admission Service -- a complete history and physical examination by a physician of a recipient admitted to a hospital in an emergency, when definitive care of the recipient is assumed subsequently by another physician on the day of admission.

Family Planning -- any medically approved means, including diagnosis, treatment, and related counseling, that assists individuals of childbearing age, including sexually active minors, in determining the number and spacing of their chilren.

433.401: continued

Family Therapy -- a session for simultaneous treatment of two or more members of a family.

Group Therapy -- application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

High-Risk Newborn Care -- care of a full-term newborn with a critical medical condition or of a premature newborn requiring intensive care.

Home or Nursing Home Visit -- a visit by a physician to a recipient at a residence, nursing facility, extended care facility, or convalescent or rest home.

Hospital Visit -- a bedside visit by a physician to a hospitalized recipient, except for routine preoperative and postoperative care.

Hysterectomy -- a medical procedure or operation for the purpose of removing the uterus.

Individual Psychotherapy -- private therapeutic services provided to a recipient to lessen or resolve emotional problems, conflicts, and disturbances.

Institutionalized Individual -- a recipient who is either:

(1) involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or

(2) confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

Intensive Care Services -- the services of a physician other than the attending physician, provided for a continuous period of hours (rather than days), required for the treatment of an unusual aspect or complication of an illness, injury, or pregnancy.

Mentally Incompetent Individual -- a recipient who has been declared mentally incompetent for any purpose by a federal, state, or local court of jurisdiction, unless the individual has been declared competent to consent to sterilization.

Not Otherwise Classified -- a term used in the lists of service codes and descriptions in Subchapter 6 of the *Physician Manual* for service codes that should be used when no other service code is appropriate for the service provided.

Oxygen -- gaseous or liquid medical-grade oxygen that conforms to United States Pharmacopoeia Standards.

Pediatric Office Visit -- a medical visit by a recipient under 21 years of age to a physician's office or to a hospital outpatient department, emergency room, or courtesy room. Well visits are not reimbursable when performed in the emergency room.

Prolonged Detention -- constant attendance to a recipient in critical condition by the attending physician.

Reconstructive Surgery -- a surgical procedure that is performed to correct, repair, or ameliorate the physical effects of physical disease or defect (for example, correction of cleft palate), or traumatic injury.

Referral -- the transfer of the total or specific care of a recipient from one physician to another. For the purposes of 130 CMR 433.000, a referral is not a consultation.

Respiratory Therapy Equipment -- a product that:

(1) is fabricated primarily and customarily for use in the domiciliary treatment of pulmonary insufficiencies for its therapeutic and remedial effect;

(2) is of proven quality and dependability; and

(3) conforms to all applicable federal and state product standards.

433.401: continued

Routine Study -- a set of X rays of an extremity that includes two or more views taken at one sitting.

Separate Procedure -- a procedure that is commonly performed as an integral part of a total service and therefore does not warrant a separate fee, but that commands a separate fee when performed as a separate entity not immediately related to other services. Such a procedure is designated "S.P." in the service descriptions in Subchapter 6 of the *Physician Manual*.

Sterilization -- any medical procedure, treatment, or operation performed to make an individual permanently incapable of reproducing.

Therapeutic Radiology Service -- a radiology service used to treat an injury or illness.

Trimester -- one of three three-month terms in a normal pregnancy. If the pregnancy has existed for less than 12 weeks, the pregnancy is in its first trimester. If the pregnancy has existed for 12 or more weeks but less than 24 weeks, the pregnancy is in its second trimester. If the pregnancy has existed for 24 or more weeks, the pregnancy is in its third trimester. For the purposes of 130 CMR 433.000, the elapsed period of gestation shall be calculated in accordance with 105 CMR (Massachusetts Department of Public Health) currently or hereafter in force.

433.402: Eligible Recipients

The Division pays for physician services provided to Medical Assistance recipients (categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8), subject to the restrictions and limitations described in 130 CMR 433.000. For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), *see* 130 CMR 450.111. Recipients participating in the MassHealth Managed Care program require service authorization before certain mental health and substance abuse services are provided. For more information, *see* 130 CMR 450.124. For regulations concerning Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, *see* 130 CMR 450.140 *et seq*.

433.403: Provider Eligibility

(A) Participating Providers.

(1) 130 CMR 433.000 applies to medical, radiology, laboratory, anesthesia, and surgery services provided to recipients by physicians participating in the Medical Assistance Program as of the date of service. A physician must have a Medical Assistance provider number before a claim will be processed by the Division.

(2) To be eligible for payment, a physician must be physically present and actively involved in the treatment of the recipient. Time periods specified in the service descriptions refer to the amount of time the physician personally spends with the recipient, except in the instances noted where the service can be performed under the direct supervision of the physician. For surgery, the physician must be scrubbed and must be present in the operating room during the major portion of an operation.

(B) In State. A physician who is licensed by the Massachusetts Board of Registration in Medicine and who meets the requirements in 130 CMR 433.403(A) is eligible to participate in the Medical Assistance Program.

(C) Out-of-State. An out-of-state physician who is licensed to practice in his state, who has obtained a Massachusetts Medical Assistance provider number, and who meets the requirements of 130 CMR 433.403(A) is eligible to participate in the Massachusetts Medical Assistance Program. The Division will pay an out-of-state physician for providing reimbursable services to a Massachusetts recipient only under the following circumstances.

(1) The physician practices in a community of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont that is within 50 miles of the Massachusetts border and provides services to a recipient who resides in a Massachusetts community near the border of that physician's state.